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Research paper

Why don't out-of-treatment individuals enter methadone treatment programmes?

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ABSTRACT

Background: Despite the proven effectiveness of methadone treatment, the majority of heroin-dependent individuals are out-of-treatment.
Methods: Twenty-six opioid-dependent adults who met the criteria for methadone maintenance who were neither seeking methadone treatment at the time of study enrollment, nor had participated in such treatment during the past 12 months, were recruited from the streets of Baltimore, Maryland through targeted sampling. Ethnographic interviews were conducted to ascertain participants' attitudes toward methadone treatment and their reasons for not seeking treatment.
Results: Barriers to treatment entry included: waiting lists, lack of money or health insurance, and requirements to possess a photo identification card. For some participants, beliefs about methadone such as real or rumored side effects, fear of withdrawal from methadone during an incarceration, or disinterest in adhering to the structure of treatment programmes kept them from applying. In addition, other participants were not willing to commit to indefinite "maintenance" but would have accepted shorter time-limited methadone treatment.
Conclusion: Barriers to treatment entry could be overcome by an infusion of public financial support to expand treatment access, which would reduce or eliminate waiting lists, waive treatment-related fees, and/or provide health insurance coverage for treatment. Treatment programmes could overcome some of the barriers by waiving their photo I.D. requirements, permitting time-limited treatment with the option to extend such treatment upon request, and working with corrections agencies to ensure continued methadone treatment upon incarceration.

Introduction

The majority of heroin-dependent individuals, both in the US and internationally, remain outside the drug use treatment system (Friedman et al., 2004; Guggenbuhl, Uchtenhagen, & Paris, 2000), costing the US an estimated $21.9 billion per year associated with lost productivity, crime, health and social service expenditures (Mark, Woody, Juday, & Kleber, 2001). Despite the proven efficacy of methadone maintenance treatment in reducing heroin use (Mattick et al., 2003) and its ability to reduce HIV transmission (Drucker, Lurie, Wodak, & Alcabes, 1998; Metzger, Navaline, & Woody, 1998; Moss et al., 1994) and criminal behavior (Ball & Ross, 1991; Campbell, Deck, & Krupski, 2007), methadone treatment is in short supply (Des Jarlais, Paone, Friedman, Peyser, & Newman, 1995; Lewis, 1999; Schwartz, Highfield, Jaffe, Callaman, & O'Grady, 2007) and even when it is available, may be hard to access (Brown, Hickey, Chung, Craig, & Jaffe, 1989; Schwartz et al., 2006; Zule & Desmond, 2000). Indeed, a recent report indicated that in Baltimore, there was a 3-month-long waiting list for methadone treatment and that only 27.5% of individuals on the waiting list entered methadone treatment within 10 months (Schwartz et al., 2007).

Prior research has demonstrated that if it were possible to readily access methadone treatment, not all opioid addicts would accept treatment when offered (Booth, Corsi, & Mikulich, 2003; Zule & Desmond, 2000). It is likely that reasons for not entering treatment differ by country and include: whether treatment is provided through specialty methadone programmes or primary care practitioners, the number of take home doses permitted, the cost of treatment and other local factors. In order to understand and address the difficulty in attracting into treatment those opioid-addicted individuals who remain outside the treatment system, it is important to clarify their views of methadone treatment. Such

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knowledge could help public policymakers, treatment providers, and public health care system administrators attract a greater percentage of opioid-addicted individuals into treatment.

While there has been research comparing the characteristics of people entering treatment to individuals not entering treatment (Booth, Crowley, & Zhang, 1996; Schwartz et al., 2008; Watters & Cheng, 1987; Zule & Desmond, 2000), there is a paucity of research that has examined the concerns regarding treatment entry from the perspectives of drug-addicted individuals (Hanson, Beschner, Walters, & Bovelle, 1985; Stancliff et al., 2002). Existing studies suggest that some out-of-treatment individuals perceive that methadone: (1) is difficult to discontinue once initiated; (2) interferes with their daily lives; (3) has serious side effects; and (4) has low "status" in the community. Data from these studies were collected between 1982 (Goldsmith, Hunt, Lipton, & Strug, 1984; Hunt, Lipton, Goldsmith, Strug, & Spunt, 1985) and 1992 (Zule & Desmond, 1998); hence, there is a need to determine whether these attitudes continue to be influential.

Purpose of the present study

This ethnographic study was part of a larger investigation conducted in Baltimore, Maryland between November 2004 and November 2007 that examined factors associated with methadone treatment entry and retention (Schwartz et al., 2008). This article focuses on the out-of-treatment sample that met the admission criteria for methadone maintenance treatment in the US, but was neither in-treatment nor was currently or had been seeking-treatment in the 12 months prior to study entry. Its primary purpose was to identify barriers to methadone maintenance and to suggest strategies for lowering those barriers.

Methods

Study participants

Out-of-treatment participants were recruited using targeted sampling techniques, described in detail elsewhere (Peterson et al., 2008). In summary, 12 areas throughout the city were chosen for recruitment based on: (1) interviews with public health officials and police; (2) a review of the data concerning rates of HIV infection; (3) crime and drug use treatment admissions; and (4) street observations. Choosing two areas per month, the recruiters approached individuals in the street, inquired about their interest in participating in the study and screened them for participation.

The inclusion criteria were: (1) 18 years old or over; (2) meeting the criteria for opioid dependence as described in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, IV Edition (APA, 1994), which includes items indicating loss of control, use in spite of adverse consequences and physiological expressions of dependence (e.g., tolerance and withdrawal); (3) meeting U.S. federal requirements for methadone maintenance treatment (i.e., at least 1 year of opioid dependence); (4) not currently seeking drug use treatment; (5) not having sought drug use treatment in the past year; and (6) willingness to provide informed consent.

As part of the larger study and prior to the ethnographic interviews, participants took part in a structured baseline interview assessing demographics, drug use and criminal justice histories, drug treatment experience, and other aspects of psychosocial functioning (Schwartz et al., 2007). The participants were recruited to the ethnographic component of the study within approximately 30 days of the baseline interview. The out of treatment ethnographic cohort was selected based on their willingness to participate in the ethnographic component of the study.

Study sample

There were 26 out-of-treatment adult opioid dependent participants who were interviewed at baseline. These individuals had a mean age of 44.5 years, 46% were men, 88% were African American, 62% were divorced or had never been married, and just over one-third reported completing less than 12 years of formal education. Twenty-seven percent of the participants had no prior drug use treatment experience, 42% reported one prior treatment experience, 19% had two previous treatments and 12% reported 3 or more prior treatments. Forty-two percent of the participants stated that they frequently used both heroin and cocaine, while 58% reported that heroin was their primary drug of choice. Forty-six percent of the participants reported injecting drugs two or more times per day within the past 6 months, on average. In terms of criminal behavior, the sample reported that for the period of 30 days prior to the interview they committed crimes on an average of 18.7 days and earned $931 in illegal income. Five (19.2%) of the participants were on probation or parole. Participants had spent an average of 47 months incarcerated in their lifetime prior to the study entry. Three participants (11.5%) reported having unstable living arrangements and eight (30.8%) reported living with a drug user. Twenty-two (84.6%) reported no employment income in the past month,

Ethnographic interviews

The majority of the out-of-treatment ethnographic interviews were conducted in locations indigenous to the research participants (e.g., participant's homes, local coffee shops, and porch steps) and at field locations in the general proximity of the neighborhoods where the participants live and congregate. This technique provided a setting familiar to the participant and an opportunity to conduct field observations of the settings in which participants live and spend time.

All ethnographic interviews began with semi-structured questions concerning participants' drug use and treatment histories and attitudes towards methadone, but the participants themselves guided the flow of the interviews. When necessary, the ethnographers asked questions in order to elicit greater detail and to clarify participants' statements. Interviews typically lasted between 30 and 60 min. All participants provided informed consent and were given $20 for each interview. The Friends Research Institute's Institutional Review Board approved the study.

Analysis

The ethnographic interviews were recorded, transcribed, reviewed for accuracy and completeness, and entered into Atlas.ti. Analyses were conducted using a modified grounded theory methodology, an approach that permits systematic analysis of data and inductively builds theory (Strauss & Corbin, 1991). The ethnographers coded data in Atlas.ti in two phases. In the open coding phase, two coders looked for descriptions of facilitators and barriers to treatment entry. Codes were compared and discussed by the two coders until consensus was reached. During the second coding phase, the data were selectively coded and categorised to reflect the reasons given by participants for seeking, entering, or not entering treatment. For this paper, we focused on the